Concordia University Athletic Department
Returning Student Athlete Packet
2010~2011

The following packet is for student athletes who are participating in the 2010-2011 athletic season. Physicals must be dated **AFTER July 1, 2010.** High School physical forms will not be accepted This packet must be completed and returned to Athletic Department **BEFORE PRACTICES BEGIN**. Failure to return all pages (13) this packet, properly completed, prior to practice beginning will result in **INABLITY TO PARTICIPATE IN PRESEASON ACTIVITIES INCLUDING CONDITIONING AND WEIGHT LIFTING**.

Please direct any questions to the CUAA Athletic Department at 734.995.7342

Attn: Athletic Department
Concordia University
4090 Geddes Road
Ann Arbor, MI 48105-2797

- ☐ Athletic Insurance Information.
- ☐ Authorization For Concordia University To Provide Emergency Care.
- ☐ Authorization To Notify Parents/Guardian Of Injury/ Illness Sustained During Athletic Participation.
- ☐ Authorization To Disclose Medical Records And Direct Payment To Medical Providers.
- ☐ Student Athlete Acknowledgment and Assumption of Risk.
- ☐ Student Athlete Has Read Insurance Policy and Procedures Concerning Primary and Secondary Insurance Coverage.
- ☐ Completed Primary Care Physician and Orthopedic Physician Choice Approved By Students Current Health Insurance Provider.
- ☐ Athletic Medical Payment Procedure. (Completed forms will remain on file in Athletic Department in the event medical payment becomes required.)
- ☐ Copies of Health Insurance, Dental Insurance & Vision Insurance Cards. (Please include copies of front and back of cards)

** FOR 2010-2011 ATHLETES ARE REQUIRED TO PROVIDE UPDATED IMMUNIZATION RECORDS, UNLESS OTHERWISE PROVIDED**

Please provide with this packet updated immunization records from your Primary care Physician.

ATHLETE'S INSURANCE INFORMATION.

SPORT _____

Name of Athlete: _____S.S.#:_____

Home Address: _____

Home Phone: ( )_____ Date of Birth:_____

Mother's Phone: work_____ Home_____

Father's Phone: work_____ Home_____

EMERGENCY CONTACT:

Name: _____ Phone:_____

Alternate Phone: _____

MEDICAL INSURANCE POLICY INFORMATION:

Type of Insurance: (e.g. HMO, PPO, etc.)_____

Policy Holder:_____

Company:_____

Address:_____

_____

Insurance Company Phone: _____

Policy #_____ Plan#_____

Group#_____ ID# _____

Expiration Date: If you have a short-term health insurance policy._____

Is the Student/Athlete covered by a Dental Insurance Plan? YES NO

Is the Student Athlete covered by a Vision/Optical Plan? YES NO

Family Physician Name _____ Phone_____

I hereby authorize Concordia University Ann Arbor to inspect or secure copies of case history records, laboratory reports, diagnosis, x-ray, and any other data covering this and/or disabilities. A photo static copy of this authorization shall be deemed valid as the original. Concordia University Ann Arbor **does not** assume responsibility for the athletes' medical expenses.

Athlete Signature_____ Date _____

Parent Signature_____ Date_____

If Athlete is under 18 years of age

If restricted by the student's insurance plan, please provide the name of a physician(s) in the Ann Arbor area that the student may be seen by.

Physician Name_____

Office Phone #_____

Address: _____

_____

I. Authorization For Concordia University To Provide Emergency Care

I _____ hereby grant the Athletic Trainers,
(First) (Middle) (Last)

team physicians, therapists, school counselor, technicians of Concordia University in contract with Med-Sport Sports Medicine Program, University of Michigan Health System, to provide any emergency and or other care that is deemed necessary to insure proper care of any injury/illness to maintain my health and well being. In the absence of the team physician, I grant permission to a qualified physician to furnish emergency care using the guidelines above. Also, when necessary for executing such care, permission for hospitalization at an accredited hospital for emergency care is granted.

Athlete/ Parent Signature_____ Date _____
Parent signature only if athlete is under 18 years of age

In case of an emergency what local emergency room or hospital can athletes visit according to the student's insurance plan? University of Michigan Hospital will be used if no hospital is listed.

Name of Hospital _____

Phone of Hospital_____

II. Authorization To Notify Parents/Guardian Of Injury/ Illness Sustained During Athletic Participation

I_____ do herby give permission for Concordia University Athletic Training Staff to release information concerning my condition/injury to my parents/guardians listed below. **This statement means that the athlete's medical information can be given to parents at anytime unless written request is given to Athletic Department**.

Athlete Signature_____ Date _____

III. Authorization To Disclose Medical Records And Direct Payment To Medical Providers.

Student athletes and parents must sign below for authorization to disclose medical records and authorization for personal insurances to make direct payments to health care providers.

I hereby authorize any insurance company, hospital, physician and/or other person who has examined the claimant to disclose, when requested to do so, all information with respect to any injury, policy coverage, medical history, consultation, or treatment and copies of all hospitals medical records.

I HEREBY AUTHORIZE MY PRIMARY PRIVATE INSURANCE COMPANY TO SEND PAYMENT DIRECTLY TO ANY FACILITIES FOR SERVICE RENDERED IN RELATION TO MY SPORTS RELATED INJURY.

Athlete / Parent Signature _____ Date _____

Parent signature only is athlete is under 18 years of age

Athlete / Parent Name printed _____

IV. Student Athlete Acknowledgment And Assumption Of Risk

The undersigned herewith formally acknowledges and declares the following:

I understand that participating in a sport requires a personal acceptance of risk of injury. I generally expect that those who are responsible for the conduct of a sport take reasonable precautions to minimize such risks and that my peers participating in the sport will not intentionally inflict wrongful injury upon me.

I understand that participating in Intercollegiate Athletics at Concordia University may result in injury/illness, permanent physical and/or mental impairment or even death. These injuries may be minor, career or life threatening. I understand Concordia University cannot be held responsible for any injuries or conditions that may be caused by the actions of other athletes or teams. I also understand that injuries caused by my own failure to follow safety procedures or techniques that are made known to me by coaching staff, athletic training staff, or by strength conditioning personnel are my own responsibility.

I understand that there are certain inherent risks involved in participating in intercollegiate athletics. I acknowledge the fact that these risks exist and I am willing to assume responsibility for any and all such risks while participating as an athlete for Concordia University. I also agree to the following:

A. I voluntarily assume all risks associated with my participation in Intercollegiate Athletics

B. I accept that Concordia University and its personnel are not to be held responsible for any pre-existing medical conditions(s) that I may have.

C. I understand that having passed the physical examination by my physician does not necessarily mean that I am physically qualified to participate in Intercollegiate Athletics at Concordia University, but only that the evaluator did not find a medical reason to disqualify me at the time of the physical examination.

D**. I understand and agree that if I experience an injury/illness or change in my health status it is my responsibility to inform my Head Coach and Certified Athletic Trainer in charge of my sport and adhere to the established injury management protocol before I am released to return to full participation. I understand that after an injury that has caused me to miss any games or practices, do to physician restrictions, I must follow up with that physician for clearance documentation to return to my sport**.

E. I understand that I must wear the proper equipment as dictated by the rules of my sport. I may also have to wear padding or braces as indicated by the Athletic Trainer or tending physician. Failure to do so may put me at risk for further injury.

Athlete / Parent Signature _____ Date _____

Parent signature only if athlete is under 18 years of age

Athlete / Parent Name printed _____

V. Concordia University's Policy & Procedures For Insurance Coverage Of Student Athletes

ALL CONCORDIA UNIVERSITY STUDENT ATHLETES MUST BE COVERED BY SOME TYPE OF INDIVIDUAL HEALTH INSURANCE BEFORE PARTICIPATING IN ANY PRACTICE, COMPETITION, OR CONDITIONING PROGRAM.

Insurance coverage for all athletic related injuries and/or illness shall be covered by student/athlete's primary health insurance first.

If an athlete does not have personal insurance coverage, they must purchase a policy through 1st Agency, Inc., or provide evidence of purchase of a similar policy. This policy will cover 50% of the reasonable and customary charges up to $25,000 prior to the secondary coverage becoming effective. The cost of this policy is $880 dollars for the entire year which paid at the beginning of the school year.

Concordia University provides a secondary accident insurance plan for its student athletes. **THIS POLICY IS SECONDARY TO, OR IN EXCESS OF PERSONAL FAMILY MEDICAL INSURANCE COVERAGE. For the secondary coverage to be accessed, the student/athlete must have stayed within the guidelines of their primary carrier.** The secondary insurance covers **only** injuries/illness/accidents resulting from the direct participation in the intercollegiate athletic program during the dates of the primary competitive season and designated off-season programs as approved by the Athletic Department according to NAIA guidelines. Concordia University's accident insurance program covers medical bills incurred within **one year** from the date of accident up to a medical maximum of $ 15,000 per accident. This layer of coverage is written in excess over any other family or employer group insurance or other plan that must contribute its maximum first, before this coverage has any liability. Maximum limit of $25,000 per accident coincides with NAIA Catastrophic coverage within 4 year period. All benefits are paid 100% of the reasonable and customary medical/dental expense incurred within benefit period. There are no co-pays or deductibles for secondary or catastrophic insurance plans.

VI. Dental Care Insurance and Vision Plan

Concordia University provides a secondary dental insurance plan after use of primary dental insurance benefits have been exhausted. **THIS POLICY IS SECONDARY TO OR IN EXCESS OF PERSONAL FAMILY DENTAL INSURANCE COVERAGE**. Concordia University's dental insurance plan covers only the cost to repair damage to natural teeth that resulted from participation in the sanctioned activities of their sport as defined by NAIA guidelines. No other dental services will be paid out by Concordia University's dental insurance plan. Dental maximum medical limitations are the same as listed above. As requested if you do participate in a family dental plan please copy front and back of card and submit it with this packet.

Concordia University's Athletic Department does not participate in any vision or contact replacement plan.

VII. Concordia University Secondary Insurance Coverage Policy For Non-Related Injury/ Illness

Concordia University's secondary insurance program is only for sports related injuries and is used in the event that the student athlete has exhausted his/her primary benefits.
If the student/athlete is being referred for an injury and/or illness that are *not* caused by participating in practices, games or conditioning, as an athlete for Concordia University, medical bills will not be covered by the secondary insurance plan. Illness/ injuries such as: sickness or disease, cancer, STDs, specific skin diseases, and OBGYN problems, any pre-existing conditions, fighting (unless an innocent victim), expenses incurred for the use of orthotics, hernia (of any kind), riding in a vehicle not provided by the University for transportation to and from practices or games, are not covered.

Concordia University has a working relationship with Eastern Michigan's Student Health Care Center. Concordia University also has student insurance plans separate from the Athletic Departments student athlete secondary insurance plan. For information on the student plan or Eastern Michigan's Student Health Services contact Concordia University's student services at 734-995-7314.

VIII. Insurance Policy Changes for Health Insurance & Dental Insurance

Athletes are responsible for knowing the specifics of their own insurance policies. Due to the amount of athletes that have varying health benefit plans it is the athletes responsibility to know who their affiliated providers are. The Athletic Department strongly encourages parents to sit down with their student athlete and discuss your/their health, dental and vision plans. Space has been provided with in this document to list approved health care providers for primary care and orthopedic physicians close to Concordia University. This will expedite the care of your student/ athlete when time of injury occurs. Concordia University has a working relationship with The University of Michigan Health Care System. Concordia University has contracted with Med-Sport which is part of The University of Michigan Health Care System to provide Athletic Training Services. To see if any of the University of Michigan's physicians participate in your health care plan you can check on line at http://ww2.med.umich.edu/healthcenters/insurance_info.cfm . Another local Health Care System is St. Josephs Hospital. You can check online to see if that hospital is within your student's health care plan at www.sjmh.com. Both internet addresses have up to date lists of insurances that Hospitals participate with. **Again, the Athletic Department highly recommends that you designate a physician that participates in your plan to help get the athlete to an approved provider so that your student athlete does not incur out of network fees or co pays.**

IT IS THE RESPONSIBILITY OF THE STUDENT ATHLETE TO NOTIFY THE ATHLETIC DEPARTMENT IF A CANCELLATION OR CHANGE OF COVERAGE OCCURS WITH YOUR PRIMARY HEALTH CARE COVERAGE. IF CANCELLATION OF POLICY OCCURS WITHOUT NOTIFICATION, ALL BILLS INCURRED DURING THAT PERIOD WILL BE THE RESPONSIBILITY OF THE STUDENT ATHLETE AND OR HIS /HER PARENTS.

IX. Concordia University's Athletic Training Coverage

A Certified Athletic Trainer has been contracted to provide medical coverage of all home events, Co-ordinate student athlete's office visits with Med-Sport orthopedic physicians and physical therapists. If the student athlete chooses to utilize health services through The University of Michigan Health Care System or another health care system it is the sole responsibility of the student athlete to know what insurance plans that local hospital accepts. If you would like more information on Med-Sport and the credentialed physicians, physical therapists and services they provide you can visit our website at http://www.med.umich.edu/medsport/.

The Athletic Department highly encourages parents to review their health insurance policies pertaining to office and emergency room co-pays before returning to campus for 2010-2011 sports seasons.

I HAVE READ, AND UNDERSTAND CONCORDIA UNIVERSITY'S POLICIES AND PROCEDURES CONCERNING HEALTH, DENTAL AND OPTICAL SECONDARY INSURANCE PLANS.

Athlete / Parent Signature _____ Date _____

Parent Signature only if Athlete is under 18 yrs of age

X. Concordia University Athletic Department Athletic Medical Payment Procedure

Medical bills incurred due to an injury while participating in intercollegiate sports programs should follow these steps to get your claim processed.

A. Submit all of the medical bills concerning your athletic injuries while participating in Concordia's Intercollegiate Athletic Program to your family or employers group health insurance plan **first.** This is your primary coverage.

   1. It is the **athlete's responsibility** to forward to your primary insurance company a copy of the bill, enrollment in college, injury, treatment etc.

   2. Your primary insurance may honor the claim and pay all portions of any bill incurred.

B. If a balance remains and you receive a denial of benefits letter from your primary insurance, usually referred to as *explanation of benefits letter*, send copies of itemized bills and letter to Concordia University's Athletic Department.

C. If the bills incurred are not paid by the family or employer group insurance plan, the claim will be sent from Concordia University's Athletic Department Secondary insurance carrier for processing.

Please note: If the primary family coverage is through an HMO (Health Maintenance Organization) or PPO (Preferred Provider Organization) you must follow proper procedures required by your plan in order for the University's insurance to complete its portion of the claim. This is especially important if your plan requires pre-authorization to be treated if out of your plan's service area.

I have fully read the above, understand and agree to these terms.

Athlete / Parent Signature _____ Date _____

Parent signature only if athlete is under 18 years of age

XI. Authorization To Release Medical Information

I _____ (print name) herby authorize Concordia University and it's agents to provide athletic training, conditioning and care for any injuries that may occur while I participate in competitive sports activities at Concordia University. I know that Concordia University has contracted with the University of Michigan Med-Sport program to provide athletic training services for student athletes.

I authorize Concordia University and Med-Sport to release information about my treatment and care of any athletic injuries to my **parents, coaching staff and members of any mental/physical health care facility involved in my care**. I authorize the release of medical information as it pertains to my medical history and current medical status after injury.

I understand that I can revoke this authorization in writing at any time. If I revoke this authorization I will not be able to participate in Concordia University Intercollegiate sports program. I also understand that hiding any previous medical condition that may alter my ability to play may result in my *immediate dismissal* from the athletic program.

Athlete / Parent Signature _____ Date_____

Parent signature only is athlete is under 18 years of age

First Agency, Inc.
5071 West H Avenue
Kalamazoo, MI 49009-8501
269-381-6630

AUTHORIZATION - To Permit Use and Disclosure of Health Information

This Authorization was prepared by First Agency, Inc. for purposes of obtaining information necessary to process a claim for benefits.

Upon presentation of the original or a photocopy of this signed Authorization, I authorize, without restriction (except psychotherapy notes), any licensed physician, medical professional, hospital or other medical-care institution, insurance support organization, pharmacy, governmental agency, insurance company, group policyholder, employer or benefit plan administrator to provide First Agency, Inc. or an agent, attorney, consumer reporting agency or independent administrator, acting on its behalf, all information concerning advice, care or treatment provided the patient, employee or deceased named below, including all information relating to, mental illness, use of drugs or use of alcohol. This Authorization also includes information provided to our health division for underwriting or claim servicing and information provided to any affiliated insurance company on previous applications. If this Authorization is for someone other than myself, that individual has given me the authority to act on his/her behalf as explained below.

I understand that I have the right to revoke this Authorization, in writing, at any time by sending written notification to my agent or to us at the above address. I understand that a revocation will not be effective to the extent we have relied on the use or disclosure of the protected health information or if my Authorization was obtained as a condition to determine my eligibility for benefits. Revocation requests must be sent in writing to the attention of the Claims Supervisor.

I understand that First Agency, Inc. may condition payment of a claim upon my signing this authorization, if the disclosure of information is necessary to determine the level or validity of the claim payment. I also understand, once information is disclosed to us pursuant to this Authorization, the information will remain protected by First Agency, Inc. in accordance with federal or state law.

I understand that I or my authorized representative is entitled to receive a copy of this authorization upon request.

This Authorization is valid from the date signed for the duration of the claim.

Name of Claimant (please print)

Name of Authorized Representative, or Next of Kin (please print)

Signature of Claimant (if claimant is 18 or older)

Date

Signature of Authorized Representative of Next of Kin

Date

Relationship of Authorized Representative or Next of Kin to Claimant

First Agency, Inc.
5071 West H Avenue
Kalamazoo, MI 49009-8501

PARENT/GUARDIAN/STUDENT INFORMATION FORM

RETURN FORM WHEN COMPLETE TO

Name of College/University Concordia University Ann Arbor

Attention Athletic Department

This form is to be completed by the Parents, Guardians or Student

Address 4090 Geddes Rd

City Ann Arbor State MI Zip 48105-2797

Note: Complete all blanks on this form. Failure to complete all blanks will result in claims processing delays.

If information is not applicable, indicate the reason it is not (e.g., deceased, divorced, unknown).

Name of Athlete _____ Sport _____

Social Security No or Passport No _____ Date of Birth _____

College Address _____ College Phone ( )

Home Address _____ Home Phone ( )

City _____ State _____ Zip _____

FATHER/GUARDIAN INFORMATION

Father's Name _____

Social Security No. _____

Date of Birth _____

Address _____

_____

Employer _____

Address _____

_____

Telephone ( )

Medical Insurance Company or Plan _____

Address _____

_____

Policy Number _____

Telephone ( )

Is this plan an HMO or PPO? ☐ Yes ☐ No

Is pre-authorization required to obtain treatment? ☐ Yes ☐ No

Is a second opinion required before surgery? ☐ Yes ☐ No

MOTHER/GUARDIAN INFORMATION

Mother's Name _____

Social Security No. _____

Date of Birth _____

Address _____

_____

Employer _____

Address _____

_____

Telephone ( )

Medical Insurance Company or Plan _____

Address _____

_____

Policy Number _____

Telephone ( )

Is this plan an HMO or PPO? ☐ Yes ☐ No

Is pre-authorization required to obtain treatment? ☐ Yes ☐ No

Is a second opinion required before surgery? ☐ Yes ☐ No

*Please note, high school physical forms will not be accepted

Concordia University Annual Physical Clearance Form
2010-2011

Name_____ Date_____ DOB____/_____/_____

Class Rank: Fresh Soph Jr Sr 5th yr Sr **Sport: _____**

Blood Pressure_____ Pulse_____ Height_____ Weight_____

Vision R 20/_____ L 20/_____ Contacts____ Glasses_____

HEENT	NORMAL	ABNORMAL	COMMENTS
Cardiac			
Lungs			
Spine			
Skin			
Abdominal			
Genitourinary			
Shoulder			
Elbows			
Wrists			
Hands			
Fingers			
Hips			
Knees			
Ankles			
Feet			

Other Medical Findings: _____

Currently taking any medications prescription or not? (including birth control) YES NO

Please List _____

I certify that I have reviewed the medical history of this athlete and recommend:

____ Clearance for athletic participation with no limits

____ Clearance, pending further evaluation or testing. Please Explain _____

____ Disqualified from participating in Intercollegiate Athletics. Please Explain

_____

Name of examining Physician _____

Signature of examining Physician_____ Date_____

Phone # _____ Fax _____

Please attach Business Card or VOID Prescription note of examining Physician for further contact regarding this physical exam. Thank You.

Returning Athlete Medical Update Form - 2010-2011

(To be completed by **returning athletes only**)

Name_____ Date_____ DOB____/_____/_____

Class Rank: Fresh Soph Jr Sr 5th yr Sr Sport: _____

School Address: _____ Phone: _____

Circle "Y" if occurred in the past 12 months, if so please explain.

1. Have you been hospitalized? Y/N
   Had Surgery? Y/N
2. Currently taking any prescription medication or pills? Y/N
   Currently taking any supplements (vitamins, creatine, N.O., etc.)? Y/N
3. Have you passed out during or after exercise? Y/N
   Have you been dizzy during or after exercise? Y/N
   Have you had chest pain during or after exercise? Y/N
   Do you tire more quickly than your friends during exercise? Y/N
   Have you had high blood pressure? Y/N
   Have you ever been told you have a heart murmur? Y/N
   Have you experienced a racing heart or skipped heartbeat? Y/N
   Has anyone in you family ever died of heart problems or a sudden death be age 50? Y/N
4. Do you have trouble breathing or cough during or after activity? Y/N
5. Have you had a head injury? Y/N
   Have you "had your bell rung" or become dizzy after hitting your head? Y/N
   Have you been "knocked out" or unconscious? Y/N
   Have you had a seizure? Y/N
   Have you had a stinger, burner, or pinched nerve? Y/N
6. Have you had heat or muscle cramps? Y/N
   Have you become dizzy or passed out in the heat? Y/N
7. Have you had problems with your vision? Y/N
   Do you wear? Contacts Glasses Protective eye wear Y/N (Please circle any you use)
8. Have you sprained/strained dislocated, fractured, broken or had repeated swelling or injured any of the following body parts (circle all that apply)?
   Head Shoulder Elbow Forearm Wrist Hand Chest Back Hip Thigh Knee Lower Leg Shin/Calf Ankle Foot
9. Had any other medical conditions (Infectious mononucleosis, Diabetes, Strep Throat)? Y/N
10. Have you had any medical problems since your last evaluation? Y/N _____
11. Did you receive any immunizations or shots in the past 12 months? Y/N
    If so, what and when? _____
12. When was your last menstrual cycle? _____
    What is the longest time between periods last year? _____

If you answered YES to any question above please explain: _____
_____

I hereby state that to the *best of my knowledge*, my answers to above questions are correct.

Athlete Signature _____ Date _____

Parent Signature (if Athlete is under 18 yrs.) _____ Date _____